

SEP 23 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

29269
Do not use this space.

1. PLACE OF DEATH

(a) County Cass Registration District No. 1124
 (b) Township Washington Primary Registration District No. 58379
 (c) City or Rich Fountain (d) Street No. R. D. St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Peter Bauer Rich Fountain R. D. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-20-1876
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
64 5 27
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 16, 1940
 I HEREBY CERTIFY, That I attended deceased from July 1, 1939, to Aug 16, 1940
 I last saw him alive on Aug 16, 1940. Death is said to have occurred on the date stated above, at 9:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Angine Pectoris
 Date of onset Aug 10, 1940
94 W

Other contributory causes of importance:
Cardiac Hypertrophy
148

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rich Fountain Mo
 13. NAME Geo. Bauer
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Westphalia Mo
 15. MAIDEN NAME Katie Hill
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy?

17. INFORMANT (ADDRESS) John Bauer
Rich Fountain Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Rich Fountain DATE 8-19, 1940

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? ✓ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Maxwell Funeral Home
Linn Mo
 20. FILED Sept 8, 1940 Mrs. W. P. Pucable
Local Registrar

Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) J. L. D. Dwyer, M. D.
 (Address) Greensburg Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Vernon Milton
Licensed Embalmer No. 4125
P. O. Address Leann, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.